INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Zoladex *goserelin implant 3.6 mg / 10.8 mg*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Locally confined prostate cancer (with flutamide), ICD 10: C61
☐ Advanced prostate cancer, ICD 10: C61
☐ Endometriosis, ICD 10: N80.9
☐ Dysfunctional uterine bleeding – endometrial thinning prior to endometrial ablation, ICD 10: N93. _____
☐ Advanced breast cancer (pre-/perimenopausal), ICD 10: C50.9 _____
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Zoladex	☐ 3.6 mg every 28 days ☐ 3.6 mg, followed 28 days later by 10.8 mg (men only) ☐ 10.8 mg every 12 weeks (men only) ☐ Continue indefinitely ☐ Number of doses: _____ For endometriosis: maximum recommended treatment duration is 6 months	Subcutaneous inj.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____